

DEPARTMENT OF SOCIAL SERVICES

744 P Street, Sacramento, CA 95814



April 1, 1991

ALL COUNTY LETTER NO. 91-30

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: WRL COURT ORDER AND IMPLEMENTATION METHODOLOGY

REFERENCES: ALL COUNTY LETTER NO: 81-58,82-15,84-15,88-57,88-105, 90-103, ACIN NO: I-53-84, I-78-87, and I-40-88.

On October 31, 1990, the Superior Court for the County of Sacramento approved the final order for the WRL v. Woods Court Case. The prospective portion of this lawsuit was implemented on December 1, 1990 with ACL 90-103. The WRL Order requires that the retroactive portion of the WRL settlement be implemented no later than May 1, 1991.

The purpose of this ACL is to implement the retroactive portion of the WRL Order. WRL class members are those AFDC applicants who applied for an immediate need payment during the retroactive period and were wrongfully denied an immediate need payment and, as a result, had their beginning date of aid delayed. The retroactive period covered by the WRL Court Order is February 4, 1982, through April 21, 1988.

This letter provides Counties with specific instructions and materials necessary for implementation of the retroactive portion of the WRL order. The WRL posters in English and Spanish for display in Food Stamp outlets and County Welfare Departments will be sent to you under a separate cover before April 15, 1991. Translated versions of the Informing/Claim Form (Temp 1785), the Notices of Action (50-019 AT through DT) and the Medi-Cal Informing Notice (Temp 1786) will also be sent to the Counties before April 15, 1991. Attached are the following materials:

- o A copy of the Draft Emergency Regulations (5/1/91 effective date).
- o Reproducible Copies of the Informing/Claim form (Temp 1785).
- o Notice of Action message language in English.
- o Reproducible Copies of the Notices of Action in English.
- o Statistical Reporting Forms (Temp 1172).

The WRL retroactive implementing regulations will be filed on or before April 22, 1991 and will have an effective date of no later than May 1, 1991. Counties should use the attached draft regulations to plan and prepare for a May 1, 1991 implementation date of the regulations. Counties will receive an adopted copy of the WRL retroactive regulations approved by the State Office of Administrative Law as soon as they are available.

Fiscal Claiming Instructions

Specific claiming instructions for the retroactive portion of the WRL court case will follow shortly in a separate County Fiscal letter. Retroactive benefits will be claimed in the normal manner as prior month supplemental payments. Separate listings of all payments claimed must be submitted to SDSS. Detailed claiming instructions will follow in the County Fiscal Letter. If there are any questions about fiscal claiming for the WRL court case, please call Ms. Sharan Fleming, Assistance Policy and Claims Unit, at (916) 324-2330.

Statistical Reports

Copies of the WRL retroactive statistical Report forms (Temp 1172) are attached. Counties must submit two reports of retroactive implementation.

The first report WRL v. Woods (A) is due October 15, 1991 and is limited to the number of Informing/Claim forms (Temp 1785) provided and the number of Informing/Claim forms received.

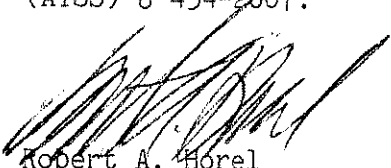
The Second report is due January 15, 1992 and contains the detailed information on the attached form WRL v. Woods (B).

If you have any questions regarding statistical reporting, please call Mr. Levy St. Mary at (916) 445-2158 or (ATSS) 8-485-2135.

Submission of Informing/Claim form

Claimants must submit an Informing/Claim form for each occurrence of a wrongful denial of an immediate need payment. Failure to timely submit an Informing/Claim form for an occurrence of potential eligibility will result in the loss of eligibility for that instance only.

If you have any questions or need any assistance regarding the retroactive provisions of the WRL Court or the attached materials, please contact Mr. Vincent Toolan at (916) 324-2007 or (ATSS) 8-454-2007.



Robert A. Horel
Deputy Director

Attachments

WRL v. Woods Retroactive Court Case

.1 Background

The WRL v. Woods lawsuit challenged the State Department of Social Services (SDSS) application of Eligibility and Assistance Standards (EAS) 40-129.28. Specifically, the complaint alleged that applicants were wrongfully denied immediate need payments and had the beginning date of aid unnecessarily delayed. On October 31, 1990, the final order settling the lawsuit was signed in Superior Court for Sacramento County. Under the terms of the order, SDSS and County Welfare Departments (CWDs) must inform current cash aid recipients about possible retroactive benefits. The provisions of the order that involve retroactivity are set forth in these regulations.

.2 Definitions

For the purposes of these regulations:

- 21 "Class members" means those individuals who:
 - .211 Applied for and were granted AFDC between February 4, 1982 and April 21, 1988; and
 - .212 Were wrongfully denied immediate need payments due to the application of EAS Section 40-129.28; and
 - .213 Had the beginning date of cash aid delayed as a result of the wrongful denial of the request for an Immediate Need payment.
- .22 "Five standard languages" means Spanish, Vietnamese, Laotian, Chinese, Cambodian.
- .23 "Immediate Need" means a condition that existed during the retroactive period when:
 - .231 The claimant had an emergency situation; and
 - .232 The claimant's resources were less than \$100; and
 - .233 The available resources could not have met the claimant's emergency situation.

- .24 "Informing/Claim form (TEMP 1785)" means the form which informs potential claimants about the court case and is used to make a claim.
 - .241 The will be printed in English and the five standard languages.
 - .241 The TEMP 1785 must be completed, signed and returned by the claimant to the appropriate CWD to initiate the claim determination process.
- .25 "Informing Notice" (TEMP 1786) means the form mailed to current recipients as a "Medi-Cal stuffer" to inform of possible retroactive benefits.
- .26 "Liquid Resources" means resources which were immediately available and reasonably convertible to cash in time to have met the claimant's emergency situation during the retroactive period.
- .27 "NOA" means a Notice of Action (NOA) that is considered to be adequate within the meaning of MPP 20-001(a). A claimant is considered to be "informed" of the outcome of a claim when the claimant is provided with a NOA.
- .28 "Responsible CWD" means the County Welfare Department that took the action on which the claimant's claim is based.
- .29 "Retroactive period" means the period of time between February 4, 1982 and April 21, 1989.

3. Informing of Possible Retroactive Benefits

HANDBOOK BEGINS

- .31 SDSS Responsibilities
 - SDSS shall:
 - .311 Include TEMP 1786 with the Medical cards issued to cash aid recipients for the month of May 1991.
 - .312 For cash aid recipients who do not receive a Medi-Cal card, mail the TEMP 1786 at the same time as Medi-Cal cards are issued for cash aid recipients for the month of May 1991.

.313 Issue Informing Posters (TEMP 1792).

- (a) The TEMP 1792 will be printed in English and Spanish with the bullets printed in Vietnamese, Laotian, Chinese and Cambodian.
 - (1) The English and Spanish entries will inform of possible retroactive benefits.
 - (2) The bullets will state (as translated): "Welfare may owe you money. You may contact the Welfare Department for a translation of this notice or call this toll free number".
- (b) Supplies of both the English and Spanish versions of the TEMP 1792 will be sent to CWDs for posting from May 1, 1991 through June 30, 1991. These supplies will be sent by SDSS no later than April 20, 1991.
- (c) Supplies of the TEMP 1792 will be sent to CWDs for provision to Food Stamp issuance offices for posting from May 1, 1991 through June 30, 1991.
- (d) Posters will be sent to up to 300 addressees to be supplied by the plaintiffs up to a maximum of 300 posters.

- .314 Make available up to \$30,000 for a summary or copy of the TEMP 1785 to be published in the newspapers or other media of plaintiff's choice.
- .315 Provide CWDs with reproducible copies of the TEMP 1785 in English and in the five standard languages.

HANDBOOK ENDS

.32 CWD Responsibilities

CWDs shall:

- .321 Post the TEMP 1792 in English and Spanish in conspicuous locations in all CWD offices from May 1, 1991 through June 30, 1991.
- .322 Forward a supply of TEMP 1792s in English and Spanish to all Food Stamp issuance outlets within the county with instructions that the posters be displayed in conspicuous locations from May 1, 1991 through June 30, 1991.
- .323 Reproduce an adequate supply of the TEMP 1785 in English and the five standard languages.
- .324 Give or mail TEMP 1785s to anyone upon request.

.4 Application for Retroactive Benefits:

.41 Claimant Responsibilities

The claimant shall:

- .411 Provide a completed (see .511) signed TEMP 1785. The TEMP 1785 must be signed under penalty of perjury.

.412 Submit the TEMP 1785 to the local CWD or to the responsible CWD. The TEMP 1785 must be submitted or postmarked if mailed no later than June 30, 1991.

(A) The claimant shall be permitted to resubmit a previously denied claim during the period from May 1, 1991 through June 30, 1991.

(B) If the original TEMP 1785 is submitted within the period, but is returned for additional information or forwarded to the responsible CWD, the date of the original submission is the date of the claim.

.42 CWD Responsibilities

When a TEMP 1785 is submitted, the CWD shall:

.421 Stamp each TEMP 1785 with the date received and retain all envelopes that were postmarked after June 30, 1991.

.422 In each case where a claim is filed, maintain all documents until the end of the claim period.

.423 Attempt to locate a case record.

.424 Determine if the CWD is the responsible CWD.

(A) If the CWD determines that it is not the responsible CWD, deny the claim, send the claimant a NOA and forward the TEMP 1785 to the responsible CWD within 15 working days from the date of receipt:

(1) The date of claim shall be the date the claim is first received by the first CWD.

(2) The first CWD shall send the responsible CWD the TEMP 1785 any supporting documentation and a copy of the NOA sent to the claimant.

- (b) If the CWD determines that it is the responsible CWD, process the claim.
- (C) If the responsible CWD cannot be determined, deny the claim and send the claimant a NOA.

.5 Claims Processing

The responsible CWD shall determine whether the claimant is a class member and take appropriate action within 60 days of receipt of the original claim. The CWD shall:

.51 Review each TEMP 1785 received.

.511 The TEMP 1785 is complete when the claimant has provided the following information:

- (a) Claimant's Social Security Number.
- (B) Case name(s) during the retroactive period.

.512 The following information shall be provided on the TEMP 1785 to the extent possible:

- (a) County(ies) of residence during the retroactive period.
- (B) The approximate date(s) of the application(s) for AFDC and request(s) for an immediate need payment during the retroactive period.
- (C) Whether AFDC was granted based on the application(s) during the retroactive period.
- (D) Whether immediate need or other assistance was granted based on the application(s) during the retroactive period.
- (E) What emergency situations the family had which it could not meet or were not met by the county based on the application(s) during the retroactive period.
- (F) Claimant's current address.

- .52 Request further information or clarification if the form lacks essential information or the information is internally inconsistent.
- .521 The CWD shall complete claim processing and pay the claim without, to the extent possible, requiring claimants to come in person to the local or the responsible CWD.
- .522 As necessary, request that the claimant supply documentation in support of the claim if such documentation is in the claimant's possession.
 - (A) As necessary, if the claimant does not have documentation in their possession, request that the claimant sign a Release of Information form (ABCDM 228 or CWD equivalent form), to allow the CWD to obtain documentation on their behalf.
 - (B) If the claimant fails to provide documentation in his/her possession or sign the Release of Information form in support of the claim, deny the claim and send a NOA to the claimant.
- .53 Compare information on the TEMP 1785 to information in the case record.
 - .531 If the information the claimant has provided on the TEMP 1785 conflicts with the information contained in the case record, use the information contained in the CWDs records to determine eligibility for retroactive benefits.
 - .532 If case record information is not available or is insufficient, use information provided by the claimant on the TEMP 1785 to determine eligibility for retroactive benefits.
- .54 If the CWD determines that the claimant is not making a claim for a class member, deny the claim and send a NOA to the claimant.

- .55 If the TEMP 1785 is not complete as specified in .511, send a NOA to the claimant to request additional information. If the County requests additional information from the claimant, the County shall have an additional 30 days from the receipt of the returned information to process the claim.
 - .56 If the original TEMP 1785 is submitted, but is not received within the period from May 1, 1991 through June 30, 1991, deny the claim and send a NOA to the claimant.
 - .57 If the CWD can find no record that the claimant applied for or received cash aid during the retroactive period, deny the claim and send an NOA to the claimant.
 - .58 If more than one eligible claim is made for a specific instance of eligibility for retroactive benefits, the first such claim filed shall be processed and any subsequent claim denied.
 - .59 If the claimant is a class member, compute and pay retroactive benefits.
- .6 Computation of Retroactive Benefits
- .61 Assistance units which are determined to be class members shall be eligible for a flat \$100 benefit for each and every time the claimant was wrongfully denied an immediate need payment during the retroactive period.
 - .611 No interest will be paid on the retroactive benefit.
 - .62 Retroactive benefits are considered corrective underpayments and therefore are not to be considered income or as resources in the month received and the following month.
 - .63 To the extent permitted by federal law and regulations retroactive benefits shall not be considered income or property in the Food Stamp program.

- .64 Retroactive benefits due and owing may be offset against outstanding recoupable overpayments. However, in no event shall such benefits be offset against an overpayment occurring prior to October 31, 1987.

Counties will ensure that retroactive benefits will not be considered as part of the grant calculations even when reported on the monthly reporting document.

.7 Statistical Reporting

- .71 The CWDs shall submit a statistical report no later than October 15, 1991 indicating:
- .711 Number of TEMP 1785s received.
- .72 The CWDs shall submit a second report no later than January 15, 1992 indicating:
- .721 Number of TEMP 1785s provided.
- .722 Number of TEMP 1785s received.
- .723 Number of claims denied because the TEMP 1785 was not received by the local or the responsible CWD before June 30, 1991.
- .724 Number of claims denied because the eligibility to retroactive benefits cannot be established based on the case record information (if any), the documentation submitted by the claimant (if any) and the TEMP 1785.
- .725 Number of claims denied because the claimant was not a class member.
- .726 Number of claims denied by the receiving CWD with a referral to another CWD
- .727 Number of claims denied because they were not submitted to the right CWD.
- .728 Number claims denied for all other reasons.
- .729 Number of claims granted.

WELFARE RECIPIENTS LEAGUE vs. WOODS CLAIM FORM

Welfare May Owe You Money

Fill out this form the best you can. You must send it to us by June 30, 1991. If your claim is late, it will be denied.

At anytime between February 4, 1982 and April 21, 1988:

YES NO

- ☐ ☐ Did you ask for cash aid?
- ☐ ☐ Did you get cash aid?
- ☐ ☐ Did you tell the County you had an immediate need or an emergency?
- ☐ ☐ Were you told you could not get an immediate need cash aid payment?

If you said YES to all four questions, welfare may owe you money.

To find out, fill out this form and give it to the County.

Use a different form for each time this happened to you.

Es posible que el condado le deba dinero. Puede ponerse en contacto con el departamento de bienestar para obtener una traducción de esta forma de reclamo, o llame al número gratuito que se menciona abajo.

ເຈົ້າສາມາດຕິດຕໍ່ບຸກຄົນໄດ້ ຫຼື ເບີເລກບຸກຄົນທີ່ຮັບການບໍລິໂພກໄດ້
ສໍາເລັດຈາກເຈົ້າ: ເລກບຸກຄົນທີ່ຮັບການບໍລິໂພກໄດ້ ຫຼື ຈຸດສະໄໝ
ການເລືອກຕັ້ງບຸກຄົນທີ່ຮັບການບໍລິໂພກໄດ້ ເລີຍກ່ອນເຈົ້າ:

ທາງຫ້ອງການປະຊາສົ່ງເຄາະອາດຕິດເງິນທ່ານ. ຖ້າທ່ານທ່ານຕ້ອງການ
ໃບຄໍາຮ້ອງຫລື ລາງຟອນຮຽກຮ້ອງໃຫ້ຈ່າຍຄືນສັບພັນທີ່ແປເປັນ
ພາສາຂອງທ່ານແລ້ວນັ້ນ, ທ່ານສາມາດຕິດຕໍ່ໄປຍັງ ຫ້ອງການປະຊາສົ່ງ
ເຄາະ ຫລືໂທໄປຕາມເລກໂທຣະສັບທີ່ບໍ່ໄດ້ເສັງຄ່າທີ່ແຈ້ງຢູ່ຂ້າງລຸ່ມນີ້.

Ty Xã Hội có thể còn thiếu tiền của quý vị. Quý vị có thể tiếp xúc với
Ty Xã Hội để xin một bản dịch của mẫu khai xin truy lãnh này hoặc
gọi cho số điện thoại miễn phí dưới đây.

郡政府可能欠你錢。需要請領表格的譯文的話，你可
以和郡福利所聯絡或者打以下不付費的電話號碼。

If you need more information call 1-800-745-5075.

Name _____

Applicant's Name
when immediate need was asked for _____

Date of Birth _____ / _____ / _____

Social Security Number _____ - _____ - _____

Fill out as many spaces as you can

Telephone Number () _____

Current Address Number/Street _____ / _____

City/State/Zip Code _____ / _____ / _____

County where you applied for immediate need

District office(s) (if known) where you applied for immediate need

About when did you ask for immediate need?

_____ 19 _____

What emergency need(s) did your family have?

For What

When

List anyone who lived with you anytime in the months you are asking for back cash aid. Include those who moved in or out.

Name

Relationship To You

You must give us your Social Security Number. We cannot approve your claim without it. We will use your number to get facts from other public agencies.

SOCIAL SECURITY ACT, SECTION 402(a)(25)

I declare under penalty of perjury under the laws of the United States of America and the State of California that to the best of my knowledge the facts in this report are true, correct and complete.

SIGNATURE

DATE

WELFARE RECIPIENTS LEAGUE vs. WOODS FORMA DE RECLAMO

Es Posible que el Departamento de Bienestar le Deba Dinero

Llene este forma lo mejor que pueda. Tiene que enviárnosla para que nos llegue a más tardar el 30 de junio de 1991. Si llega tarde su reclamo, se le negará.

En cualquier tiempo entre el 4 de febrero de 1982, y el 21 de abril de 1988:

SI NO

- ☐ ☐ ¿Solicitó asistencia monetaria?
- ☐ ☐ ¿Recibió asistencia monetaria?
- ☐ ☐ ¿Le dijo al condado que tenía una necesidad inmediata, o una emergencia?
- ☐ ☐ ¿Le dijeron a usted que no podía recibir un pago de asistencia monetaria por necesidad inmediata?

Si contestó SI a las cuatro preguntas, es posible que el departamento de bienestar le deba dinero.

Para darse cuenta, llene esta forma y désela al condado.

Use una forma diferente para cada vez que le haya sucedido esto.

ເຈາະຈີ້ກວດຕິດກັບບັງຄັບເລກກູ້ກູ້ ກໍ ເປັນເລກກູ້ກູ້ທີ່ບໍ່ມີການບັງຄັບໄປສູ່
ສົມເດັດຈາຍຈາຍເລະ ເລກກູ້ກູ້ກວດຕິດກັບບັງຄັບເລກກູ້ກູ້ ຫຼື ຈຸນລະດັບ
ຕາຍເລກກູ້ກູ້ທີ່ບັງຄັບເລກກູ້ກູ້ເລີຍກວດຕິດກັບເລກກູ້ກູ້ ກໍ

ທາງຫ້ອງການປະຊາສົ່ງເຄາະອາດຕິດເງິນທຸກ. ຖ້າຫາກທ່ານຕ້ອງການ
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ເຄາະ ຫລືໂທໄປຕາມເລກໂທຣະສັບທີ່ບໍ່ໄດ້ເສັຽຄ່າທີ່ແຈ້ງຢູ່ຂ້າງລຸ່ມນີ້.

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Ty Xã Hội để xin một bản dịch của mẫu khai xin truy lãnh này hoặc
gọi cho số điện thoại miễn phí dưới đây.

郡政府可能欠你錢。需要請領表格的譯文的話，你可以
和郡福利所聯絡或者打以下不付費的電話號碼。

Si necesita más información, llame al 1-800-745-5075.

Nombre _____

Nombre del solicitante
cuando se solicitó necesidad inmediata _____

Fecha de nacimiento _____ / _____ / _____

Número del Seguro Social _____ - _____ - _____

Llene tantos espacios como pueda

Número de teléfono () _____

Dirección actual, número y calle _____ / _____

Ciudad/Estado/Zona postal _____ / _____ / _____

Condado donde usted solicitó necesidad inmediata

Oficina(s) de distrito (si la sabe) donde solicitó necesidad inmediata

¿Aproximadamente cuándo pidió necesidad inmediata?

_____ de _____ de 19 _____

¿Qué clase de emergencia(s) tuvo su familia?

¿Para qué?

¿Cuándo?

Enumere a las personas que vivieron con usted, en cualquier momento, en los meses para los que pide asistencia retroactiva. Incluya a las personas que se mudaron a con usted, o se fueron.

Nombre	Parentesco con usted

Tiene que darnos su número del Seguro Social. No podemos aprobar su reclamo sin él. Usaremos su número para obtener datos de otras dependencias públicas.

SECCION 402(a)(25), del ACTA DEL SEGURO SOCIAL

Declaro bajo pena de perjurio, bajo las leyes de los Estados Unidos de América, y del Estado de California, que conforme mi mejor entendimiento, los datos que hay en este reporte, son verdaderos, correctos y completos.

FIRMA	FECHA

State of California
Department of Social Services

Manual Msg. No.: M50-019At
Action: Retro
Reason: Im Need
Title: Approve

Auto ID No. :
Flow Chart No. :
Source : WRL
Regulation Cite: 50-019, WRL v. Woods

Form No. : NA290
Effective Date : 03/27/91, new
Revision Date :

MESSAGE: As of _____, the County has approved your back cash aid for \$ _____.

Here's why:

You were denied an immediate need payment, and your cash aid started late. A court order says we must give you \$100 for each time you were denied an immediate need payment and should have got it. This is to pay you back for starting your cash aid late. Your back cash aid amount is figured on this notice.

[] A check will be sent soon.

[] A check is enclosed.

If you are on cash aid this check will not be counted as income.

Computation to be shown in right hand column of NOA:

Month	Year	Amount
_____	_____	\$ _____
_____	_____	_____
_____	_____	_____
Total Amount		\$ _____

INSTRUCTIONS: Use for retroactive cases that were denied immediate need payments. Fill in the effective date and the amount of back cash aid. Check the appropriate disposition of the check.

Computation: Show the back cash aid computation in the right hand column. Show the month and year, and show \$100 for each wrongful denial of immediate need. Fill in total amount.

Auto ID No. :
Flow Chart No. :
Source : WRL
Regulation Cite: 50-019, WRL v. Woods

Form No. : NA 290
Effective Date : 03/27/91, new
Revision Date :

MESSAGE: We have denied your claim for back cash aid for the month of _____ dated _____.

Here's why:

- ☐ Your cash aid was not started late.
- ☐ You were not eligible for cash aid.
- ☐ You got an immediate need payment.
- ☐ You were not eligible for immediate need.
- ☐ You did not ask for immediate need between February 4, 1982 and April 21, 1988.
- ☐ You did not give us your claim by _____.
- ☐ You did not return a complete claim form by _____.
- ☐ Other:

INSTRUCTIONS: Use to deny a claim for back cash aid based on the WRL court case. Check the appropriate box to indicate the reason for denial. If the reason is not listed, check the "other" box and fill in the reason for denial. Fill in the date where necessary.

State of California
Department of Social Services

Manual Msg. NO.: M50-01900
Action : Retro
Reason: Im Need
Title: Retroactive Denial,
Wrong County
Form No. : NA290
Effective Date : 03/27/91, new
Revision Date :

Auto ID No. :
Flow Chart No. :
Source : WRL
Regulation Cite: 50-019, WRL v. Woods

MESSAGE: We have denied your claim for back cash aid for the month of _____ dated _____.

Here's why:

You did not apply for or get cash aid from this County.

The claim must go to the County where you applied for and got cash aid between February 4, 1982 and April 21, 1988.

[] You must send your claim to the right County by _____.

[] We have sent your claim to _____ County. You will get another notice from them.

INSTRUCTIONS: Use when the claimant submitted the Informing/Claim form to the wrong County. Fill in the County name when transmitting the claim to the correct County.

State of California
Department of Social Services

Manual Msg. No.: M50-019Dt
Action: Retro
Reason: Im Need
Title: Request for
Information
Form No.: NA290
Effective Date: 03/27/91, new
Revision Date:

Auto ID No.:
Flow Chart No.:
Source: WRL
Regulation Cite: 50-019, WRL v. Woods

MESSAGE: The County needs more facts on your Welfare Recipients League v. Woods claim dated _____.

Fill in the circled parts of the attached claim form.

Send or bring the completed form by _____. If we don't have it by this date, your claim will be denied.

INSTRUCTIONS: Check the box or boxes of the form(s) needed to process the claim. Fill in the date blanks of the NOA message.

NOTICE OF ACTION

COUNTY OF _____

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

Notice Date : _____
Case : _____
Name : _____
Number : _____
Worker : _____
Name : _____
Number : _____
Telephone : _____
Address : _____

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how. Your benefits may not be changed if you ask for a hearing before this action takes place.

As of _____, the County has approved your back cash aid for \$ _____.

Here's why:

You were denied an immediate need payment, and your cash aid started late. A court order says we must give you \$100 for each time you were denied an immediate need payment and should have got it. This is to pay you back for starting your cash aid late. Your back cash aid amount is figured on this notice.

☐ A check will be sent soon.

☐ A check is enclosed.

If you are on cash aid this check will not be counted as income.

Month	Year	Amount
_____	_____	\$ _____
_____	_____	_____
_____	_____	_____
Total Amount		\$ _____

Rules: These rules apply. You may review them at your welfare office: MPP 50-019, WRL v. Woods.

NOTICE OF ACTION

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

Notice Date _____
Case _____
Name _____
Number _____
Worker _____
Name _____
Number _____
Telephone _____
Address _____

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how. Your benefits may not be changed if you ask for a hearing before this action takes place.

We have denied your claim for back cash aid for the month of _____ dated _____.

Here's why:

- ☐ Your cash aid was not started late.
- ☐ You were not eligible for cash aid.
- ☐ You got an immediate need payment.
- ☐ You were not eligible for immediate need.
- ☐ You did not ask for immediate need between February 4, 1982 and April 21, 1988.
- ☐ You did not give us your claim by _____.
- ☐ You did not return a complete claim form by _____.
- ☐ Other:

Rules: These rules apply. You may review them at your welfare office: MPP 50-019, WRL v. Woods.

NOTICE OF ACTION

Notice Date
Case
Name
Number
Worker
Name
Number
Telephone
Address

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how. Your benefits may not be changed if you ask for a hearing before this action takes place.

We have denied your claim for back cash aid for the month of _____ dated _____.

Here's why:

You did not apply for or get cash aid from this County.

The claim must go to the County where you applied for and got cash aid between February 4, 1982 and April 21, 1988.

☐ You must send your claim to the right County by _____

☐ We have sent your claim to _____ County. You will get another notice from them.

Rules: These rules apply. You may review them at your welfare office: MPP 50-019, WRL v. Woods.

NOTICE OF ACTION

COUNTY OF

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY
DEPARTMENT OF SOCIAL SERVICES

Notice Date _____
Case _____
Name _____
Number _____
Worker _____
Name _____
Number _____
Telephone _____
Address _____

(ADDRESSEE)

Questions? Ask your Worker.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how. Your benefits may not be changed if you ask for a hearing before this action takes place.

The County needs more facts on your Welfare Recipients
League v. Woods claim dated _____.

Fill in the circled parts of the attached claim form.

Send or bring the completed form by _____.

If we don't have it by this date, your claim will be denied.

Rules: These rules apply. You may review them at your welfare office: MPP 50-019, WRL v. Woods.

STATISTICAL REPORT

SEND ONE COPY TO:

Department of Social Services
Statistical Services Bureau
744 P Street, M.S. 19-81
Sacramento, CA 95814
(916) 322-2230**WRL v. Woods (A)**

NAME OF COUNTY SUBMITTING REPORT

THIS REPORT IS DUE ON OR BEFORE:

October 15, 1991

THIS REPORT IS

☐

ORIGINAL SUBMISSION

☐SUBSEQUENT REPORT
NO. _____☐

REVISION NO. _____

REPORTING PERIOD

FROM: **May 1, 1991**TO: **June 30, 1991**

1. Total number of claim forms provided to claimants
during the reporting period:..... _____
2. Total number of claims received by the county
during the reporting period:..... _____

NOTE: Claim dispositions will be reported on WRL vs. Woods (B)

PERSON TO CONTACT REGARDING THIS REPORT

TELEPHONE NUMBER

DATE

STATISTICAL REPORT

SEND ONE COPY TO:

Department of Social Services
Statistical Services Bureau
744 P Street, M.S. 19-81
Sacramento, CA 95814
(916) 322-2230

WRL v. Woods (B)

NAME OF COUNTY SUBMITTING REPORT

THIS REPORT IS DUE ON OR BEFORE:

January 15, 1992

THIS REPORT IS

☐

ORIGINAL SUBMISSION

☐SUBSEQUENT REPORT
NO. _____☐

REVISION NO. _____

REPORTING PERIOD

FROM: **May 1, 1991**TO: **June 30, 1991**

1. Total number of claims received..... _____
 - a. Received during 5/1/91 - 6/30/91 reporting period..... _____
 - b. Received during 7/1/91 - 12/31/91 time period..... _____
2. Total number of claims approved/granted..... _____
3. Total number of claims denied (between May 1, 1991 and December 31, 1991)..... _____
 - a. Denied as untimely..... _____
 - b. Denied as incomplete..... _____
 - c. Denied because claimant was not a member at the class..... _____
 - d. Wrong County w/referral..... _____
 - e. Wrong County..... _____
 - f. Other denials..... _____

PERSON TO CONTACT REGARDING THIS REPORT

TELEPHONE NUMBER

DATE